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| *Part 417 (Cost plans non-renewal)* | We asked for comment on our approach to non-renew where there are two or more MA plans of the same type meeting minimum enrollment requirements in a portion of the cost plan's service area. | We confirmed in the preamble that we will non-renew cost plans piecemeal, in areas where they have competition (two or more plans). |
| *Part 422* | | |
| *Subpart A* | | |
| Disproportionate Percentage in Special Needs Plans (SNPs) | We indicated that we have the authority to allow plans to enroll a disproportionate number of beneficiaries from any of the Special needs Individuals Categories and be considered a SNP. | We allow SNPS to enroll a disproportionate percentage of Special Needs Individuals. We define disproportionate as a plan that enrolls a greater proportion of the target group than occur nationally in Medicare population. We will provide additional guidance on the data on prevalence of chronic conditions, Medicaid and institutionalized in the Medicare population. |
| Definition of Severe or Disabling Chronic Condition | In the proposed rule, we requested input on how to define an individual with a severe or disabling chronic condition. | CMS will not define severe or disabling chronic condition in the final regulation, but will review plans' proposals based on appropriateness of target population, existence of clinical programs or special expertise, and not discriminating against "sicker" members of target population. |
| Clarifying Definitions of Institution and Institutionalized | Define "institutionalized" as residing in a long-term care facility for more than 90 days as determined by the presence of a 90-day assessment in MDS | We are defining institutionalized for purposes of special needs individuals as a beneficiary who resides or is expected to reside in a ) a long term care facility that is a SNF, NF, SNF/NF, inpatient psychiatric facility or ICF/MR.for 90-days or more. Enrollment prior to a 90-day stay must be based on a CMS-approved assessment. This may include those living in the community but requiring an equivalent level-of-care |
| SNPs Requirement to provide Part D Coverage | Proposed requiring SNPs to cover part D | We will require SNPs to provide Part D |
| *Subpart B* | | |
| Enrolling subgroups of dual eligible and institutionalized | Requested comment on allowing subgroups of these two categories | CMS will consider requests for SNPs that serve subsets of categories of special needs individuals (preamble language) |
| ESRD Waiver | Requested comment on allowing ESRD individuals to enroll in SNPs | CMS may waive the provision that precludes ESRD individuals from enrolling in SNP |
| Deemed Continued Eligibility | Proposed applying to individuals who, in absence of continued coverage in SNP, | Deemed continued eligibility will apply to those SNP individuals who no longer meet plans' unique eligibility criteria who can reasonably be expected |

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| | would reasonable be expected to regain eligibility within a period not to exceed 6 months | to again meet criteria; deemed eligibility period must be a minimum of 30 days, not to exceed 6 months |
| "Grandfathered" individuals in "redesignated" plans | Proposed allowing grandfathering but also requested comment on alternative of involuntary disenrollment | Members of "redesignated" plans will be grandfathered; CMS will establish SEP |
| Disenroll individuals who no longer meet unique SNP eligibility criteria | Requires SNPs to disenroll those who no longer meet unique criteria (after allowing for any applicable deemed continued eligibility) | Requires SNPs which exclusively serve SNP individuals (with exception of grandfathered individuals) to disenroll those who no longer meet unique criteria |
| Coordination of Enrollment - Default enrollment | Requested comment | Revised final rule to allow, on a case by case basis as approved by CMS, for organizations to "convert" commercial members into their MA offering upon the individual's entitlement to Medicare |
| Non payment of premium | Decreased the grace period | Revised to include a "one month" minimum |
| Disruptive Behavior | Revised provision | Revised provision to focus on behavior that impacted the plan's ability to furnish services. Added additional protections, such as review of case by CMS staff with medical or clinical expertise. Eliminated expedited provisions. |
| *Subpart C* | | |
| Ensure hospital access for regional MA plan enrollees in rural areas, where contracting may be difficult | Some plans expressed concern about rural hospitals unwillingness to participate. We asked for comment and developed the following considerations in light of this concern. | The essential hospital payment is made to a non-contracting hospital that treats an MA regional plan enrollee when specified conditions are met. We include in the final regulation that a Critical Access Hospital (CAH) is not an "essential hospital." Further, we point out that an essential hospital is defined as one in which there is no competition in an area (fewer than two hospitals under different ownership/control) We note that CMS will evaluate MA regional plan's designation of "essential hospital" status, including proof of hospital's refusal to contract. An MA regional plan must prove it offered at least the FFS reimbursement rate. Once a hospital is designated as an "essential hospital," in-network cost sharing applies. |
| Written Coverage Decisions | We proposed that an MA regional plan may elect to have any local coverage determination that that applies in any part | We are specifying that if the MA regional plan elects the option to apply a uniform LCD, it must elect a single fee for service contractor's group of local coverage determinations or policies to apply to all to all parts of that same MA |

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| | of an MA region apply to all parts of that same MA region. | region . We require the MA plan to provide access to local coverage determinations, including through the internet, for providers and information on the network for beneficiaries. |
| *Subpart D* | No Substantial Changes | |
| *Subpart E* | No Substantial Changes | |
| *Subpart F* | | |
| Exceptions to annual contracting | In the proposed rule, we stated that we would no longer allow plans to enter the program with a new plan or to offer mid-year enhancements to an existing plan. | We will allow an exception to the annual contracting requirement for new PACE plans, and employer-group health plans not open to general enrollment. Service area expansions could be approved for plans whose Part D bids are not included in national average bid or for plans not offering Part D benefits. |
| Mid Year Benefit Enhancements | | We will generally allow MYBE's for non-drug benefits if they will be effective between July 1 and September 1 in a contract year and the application for the MYBE is received before July 31. |
| Eliminating plan assumptions about utlilization effects of non drug cost sharing | We proposed that the basis A/B bid should assume a utilization pattern consistent with Medicare cost-sharing. | We've eliminated the language for plans to make assumptions about utililization effects of non drug cost sharing |
| Bidding Methodology for ESRD | We proposed that ESRD enrollees be fully incorporated into the plan's aggregate bid for contract year 2007 and succeeding years and invited comments on 3 options how we should handle ESRD for 2006. | We will not implement the merged bid for ESRD for 2006, because of different phase in of risk adjustment methodology (100% for ESRD versus 75% for non-ESRD) |
| Determining Actuarially Equivalent Cost Sharing | The proposed rule described how the MMA amended section 1852(a)(1)(B) of the Act to define benefits under the original Medicare fee-for-service program option as those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part | We believe that the proportional approach is the best approach, based on local proportions that are service specific. |

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| | A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part (Cost sharing refers to service-specific cost sharing for A/B benefits; it does not include a beneficiary premium.)<br><br>Further, the proposed regulation described how the new Sec. 1852 provision does not determine what a plan's actual cost sharing structure will be, because under Sec. 1854(e)(4) a plan can have an actuarial value of cost sharing that is less than that under original Medicare, if the plan rebate has been applied to a buy down plan cost sharing.<br><br>Thus, the NPRM proposed three alternative approaches to determining the actuarial value of cost sharing: (1) localized uniform dollar amount; (2) plan-specific approach; and (3) proportional approach. We asked for comment on these approaches and received comments on the preferred approach. | |
| *Subpart G* | | |
| Standards for Bid Review | | We clarified in the preamble a number of the bid review processes to respond to numerous comments. However, very little resulted in regulatory text changes. |

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| Geographic Adjustment to MA Plans Payments ("ISAR") | In the Proposed rule, we described how Section 1853(a)(1)(F) requires that CMS adjust payments for local and regional plans "in a manner to take into account variations in MA local payment rates...among the different local areas" included in the service area or region.<br><br>We interpreted variation to mean the underlying costs the plan faces, averaged across the service area, because the MMA defines the bid to be an amount that reflects a plan's estimated revenue requirements (i.e. cost in the service area).<br><br>By law, a plan's bid is based on its projected enrollment. The purpose of the ISAR adjustment is to take into account the difference between the distribution of enrollment across counties in the plan's service area that is assumed in the plan's bid (projected enrollment) and the actual geographic mix of enrollment at the time payment is made.<br><br>Since plan costs are likely not uniform across the plan's service area, the fact that the distribution of enrollment assumed in the bid is not the same as the distribution of actual enrollment would impact on whether the plan receives the revenue it indicated it needed in its bid to provide Medicare A/B services. Therefore, instead | We are specifying MA plan rates as the method to be used in calculating the ISAR adjustment. On an case-by-case basis, MA regional plans (but not local plans) may provide justification for using plan-specific information as the ISAR adjustment. CMS will carefully review each exception request. We will provide further detail about the ISAR adjustment and methodology in the 45 day advance notice. |

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| | of paying plans the same bid amount for each county in the service area (since the basic A/B bid is based on projected enrollment), we would pay for the distribution of actual enrollment by using ISAR-adjusted county rates that represent the bid-equivalent rates.<br><br>The NPRM proposes four options for creating a relative cost index to use to adjust the bid: input price index, MA rates, FFS rates, and plan-submitted index. | |
| *Subpart I* | No substantial Change | |
| *Subpart J* | | |
| Moratorium on Local Plans | We had proposed that no new Local preferred provider organization plens could be offered between 1/1/06 and 12/31/07 unless the plan was already offered as of December 31, 2005. | We have revised our interpretation of the moratorium as restricting the offering of local PPO plans by MA organizations that had not offered a local PPO plan in the service area as of December 31, 2005. This means that local PPOs already offering a local PPO plan in an area as of December 31, 2005 may offer new plans within that service areas in 2006 and 2007, but may not expand the service area. |
| Approval of Employer Groups as MA regional plans. | Regional MA plans qualify for Stabilization fund payments beginning in 2007 To what extent can we, or should we, preclude MA plans that are <u>not</u> open to general enrollment (such as employer group-only plans) from being offered as Regional MA plans so that they may receive stabilization fund and other incentives?<br><br>Under both §1857(i)(1) and (2), the | We've adopted a policy of not approving Employer group waivers that would permit a Regional MA plan to limit enrollment to members of an employer group. |

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| | Secretary has discretion to waive program requirements in order to facilitate employer/union group enrollment. In the case of local MA plans, CMS has exercised this discretion to waive the requirement that all MA eligible beneficiaries living in an MA plan service area be permitted to enroll in any MA plan offered in that area. Instead, under waivers approved by CMS, some local MA employer plans limit enrollment to members of an employee group or groups. | |
| *Subpart K* | We proposed that we have one set of contract application requirements and determinations wherever practicable between MA Part D plan sponsors, and for any other comments that would make the application and contract process simpler and less lengthy.<br>We solicited comments on our proposal to require MA plans to self-report misconduct it believes may violate various criminal, civil or administrative authorities. | We have adopted the following:<br>1. Bidding is not appealable in the contract application process under subpart N. An unsuccessful bid is considered a mutual termination of the contract between CMS and the contract applicant.<br><br>2.We eliminated, as a separate and distinct step in the review process, notification that an application is incomplete.<br><br>3. Added language making clear that both the initial contract and renewal are contingent on the bid being approved.<br><br>4. Changed the amount of time for an applicant to respond for an Intent to Deny Notice from 60 days to 10 days.<br><br>5. Revised to require MA organizations to retain records for 10 years from the latest contracting period or audit.<br><br>6. Eliminated proposed requirement for mandatory self- reporting of potential F&A violations. |

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| *Subpart L* | No Changes in NPRM | We changed §422.550 (A) (2) to read: Asset *transfer*. (formerly sale) This was done to maintain consistency with Title I subpart L. |
| *Subpart M* | | |
| | We proposed the elimination of the practitioner's notice requirement set forth in §422.568(c). This section required that at each patient encounter with an MA enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the MA organization regarding any decision to deny services to an enrollee. | Instead of requiring practitioners to provide general notices to enrollees at each patient encounter, MA organizations will provide information on appeal rights at physicians' offices in the evidence of coverage, and provide specific written notice for MA organization denials. |
| | | |
| | We solicited comments on whether to permit or require network and non-network providers to furnish enrollees advance beneficiary notices (ABNs) when they access non-Medicare covered services, or when they face potential liability for out of network services that would be otherwise payable by the MA plan if proper referral were obtained. | Based on public comments, we are not implementing the use of ABNs in managed care settings. |
| | We proposed under §§417.600(b) and 417.840 that the same rights, procedures, and requirements relating to beneficiary appeals and grievances required under MA also apply to Medicare cost plans and HCPPs. This change would establish uniform grievance and appeal procedures for all Medicare managed care plans. | We will require that cost plans and HCPPs must transition to the MA grievance and appeals processes under Part 422 no later than January 1, 2006. |

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| | Section 232(a) of the MMA changes the presumption from one in which State laws are not preempted unless they conflict with Federal laws or fall into specified categories to one in which State standards are presumed preempted unless they are licensing or solvency laws. Thus, we solicited comments on whether CMS should adopt the grievance provisions proposed in our January 24, 2001 proposed rule that would require MA organizations to establish notice and timeliness procedures. | We have incorporated the specific grievance procedures outlined in our January 24, 2001 proposed rule that would require MA organizations to establish notice and timeliness procedures. |
| | We solicited comments on whether, and to what extent, the application of ERISA and Medicare appeal procedures might be a problem for plans, employers and/or eligible individuals when an employer, by contracting with an MA plan, provides health benefits in addition to those covered under Part C. | We have added §422.560(c), which is intended to give ERISA plans the option, pursuant to regulations of the Secretary of Labor, of electing the MA process rather than the ERISA procedures. This provision would not take effect in the absence of regulations by the Secretary of Labor. |
| *Subpart N* | Not included in NPRM. | We have made July 15 the cut-off date for the conclusion of contract application determinations. After that an applicant would be ineligible to contract with us for the next CY period. This was done to maintain consistency with Title I, Subpart N. |
| *Subpart O* | No substantial Changes in NPRM. | We have made some editorial revisions and clarified at Basis for Imposing Sanctions §422.752 (a) that we may impose one, or more, of the sanctions |

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| | | specified in §422.750(a)(2), (a)(3), or (a)(4). |